DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1105 (Rev. 1/00)

This form consists of six (6) two-ply pages. This is page 1.

Agency Name:_____
Agency Telephone Number:_____
EDC:_____

PREGNANCY QUESTIONNAIRE

A. GENERAL INFORMATION

1. Mother's Name and Address: (*Please print)*

   _____
   Last Name First Middle

   _____
   Street Address

   _____
   City State Zip Code

2. Mother's date of birth: _____

3. Age: _____

4. Medicaid ID#: _____

5. Telephone number:
   (home)_____
   (work)_____
   No phone, or phone is often disconnected.

6. How can we contact you?
   Call home Call work
   Write home Other: _____

7. Are you:
   Single (never married, separated, divorced, widowed)
   Married

8. Your race/ethnic origin:
   White African-American
   Hispanic American Indian
   Southeast Asian Other: _____

9. Do you speak English?
   Very well
   A little
   Not at all

10. Do you read English?
    Very well
    A little
    Not at all

11. Are you in a WIC Program?
    No Location: _____
    Yes I was denied
    I just applied I don't know about WIC

12. What are your sources of income? *(Please check all that apply.)*
    Self Parents
    Partner/Spouse Alimony
    Child support payments
    Unemployment benefits
    Other: _____

13. Are you employed?
    No
    Yes
    I am a student
    If you are employed, what is your occupation?
    _____

    If you are employed, how many hours do you usually work in a week? _____

14. What was the last grade you finished in school? _____

    If in school now do you attend regularly?
    No
    Yes
    I am working on GED or have completed it.

15. Have you in the past, or are you currently, receiving special educational services or exceptional education services?
    No
    Yes

16. Where do you live?
    House /Mobile Home
    Apartment
    Homeless (includes shelter, hotel, motel)
    With other family members or friends

17. How many times have you moved in the last year?
    _____

18. Name address, and telephone number of parent, guardian, or person to contact in an emergency:
    _____
    _____
    Street Address
    _____
    City State Zip Code
    Telephone number: _____
    What relation is this person to you? _____

B. ABOUT THIS PREGNANCY

1. How far along are you now?
   ____ weeks (or) ____months
   I don't know

2. How far along were you when you started seeing a medical provider (doctor, nurse midwife or nurse practitioner) for prenatal care?
   ____ weeks (or) ____months
   I haven't seen anyone yet
   I have an appointment

3. Have you seen your medical provider at least monthly for this pregnancy?
   No
   Yes

4. Did this pregnancy come less than a year after your last pregnancy?
   No
   Yes

5. Are you pregnant with more than one baby?
   No
   Yes
   I don't know

6. Have you had any early signs of labor?
   No
   Yes

7. Have you gone to the emergency room or hospital for this pregnancy?
   No
   Yes

8. Would you like more information or help with any of these things?
   The baby's growth
   How to eat right during pregnancy
   What to expect during labor and delivery
   Breastfeeding
   How to take care of your infant or older children
   Family planning
   Other: _____

C. YOUR MEDICAL HISTORY

1. Do you have, or have you ever had any of these conditions? *(Please check the boxes that apply to you.)*
   Asthma and taking medication
   Chlamydia or gonorrhea (clap)
   Anemia (i.e., "low blood or iron" of pregnancy)
   Chronic kidney disease
   Diabetes
   Epilepsy or seizures
   Exposure to TB in your household
   Heart Disease
   Eating Disorder
   Hepatitis B
   High blood pressure during pregnancy (e.g., preeclampsia, toxemia)
   Kidney/bladder infections
   Mental health problems
   Physical or sensor disabilities (e.g., deaf or blind)
   Genetic disease (e.g., sickle cell, cystic fibrosis, PKU, hemophilia)
   Syphilis
   Genital herpes
   Other medical problem. If so, list them here:
   _____

2. How many times have you been pregnant before this pregnancy? _____ times
   Never

3. Have you had any miscarriages?
   No
   Yes _____ How many?

4. Have you had any abortions?
   No
   Yes _____ How many?

(If this is the first time you have ever been pregnant, skip the questions below and answer the questions in Part D. Thank you.)

5. Have you had twins, or multiple births?
   No
   Yes

6. Have you ever had a C-section?
   No
   Yes

Key > = greater than
< = less than

Points (subtotal)_____

7. Were any of your babies born more than 3 weeks early?
   No
   Yes How many?_____

8. Did a doctor ever say you had premature labor that required bed rest, medication, and/or hospitalization?
   No
   Yes How many?_____

9. Have you had a stillborn baby (born dead after 20 weeks), or that died soon after birth?
   No
   Yes How many?_____

10. Did any of your babies weigh less than 5 pounds at birth?
    No
    Yes How many?_____

11. Did any weigh more than 10 pounds at birth?
    No
    Yes How many?_____

12. Did any stay more than one day in a special care nursery?
    No
    Yes How many?_____

13. When did you start prenatal care during your last pregnancy?
    I did not continue with that other pregnancy
    I did not get any prenatal care
    1st - 3rd month
    4th - 6th month
    7th - 9th month

D. TOBACCO, ALCOHOL, MEDICINES AND OTHER DRUGS

1. During the 3 months before you were pregnant, on average, how many cigarettes did you smoke a day?
   More than 2 packs a day
   1 or 2 packs a day
   About a pack a day
   About a half pack a day
   About 4 or 5 cigarettes a day
   I don't smoke

2. On average, how many cigarettes do you smoke a day now?
   More than 2 packs a day
   1 or 2 packs a day
   About a pack a day
   About a half pack a day
   About 4 or 5 cigarettes a day (or 2 to 6)
   I live with someone who smokes
   I don't smoke

*We would like to ask you a few questions about drinking. It will help us take better care of you and your baby. Think back to 3 months **before** you became pregnant. Be sure to include beer, wine, and liquor in your answers to these questions.*

3. How many drinks does it take to make you feel high? _____ drinks
   I never drink

4. How much can you hold? _____ drinks
   I never drink
   I don't know

5. Have people annoyed you by criticizing your drinking?
   No
   Yes
   I never drink

6. Have you ever felt you ought to cut down on your drinking?
   No
   Yes
   I never drink

7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
   No
   Yes
   I never drink

8. **Since you became pregnant,** about how many days in a month do you have 3 or more drinks?
   (If none, write zero.) _____ days per month

9. **Since you became pregnant,** about how many days in a month do you have one or more drinks?
   (If none, write zero.) _____ days per month

10. Have you taken any prescription drugs since you became pregnant?
    No
    Yes
    (Please list them here.)
    _____
    _____

Key > = greater than
< = less than

Points (subtotal)_____

11. Have you taken any over-the-counter drugs since you became pregnant?
    No
    Yes
    (Please list them here.)
    _____
    _____

12. Have you ever injected a non-prescribed drug?
    No *(Skip to question 15)*
    Yes

13. Number of different persons with whom you shared intravenous drug needles or syringes, or "works" within the last:
    10 years _____ last 12 months _____

14. Do you think any of these persons were infected with HIV (the AIDS virus)?
    No
    Yes
    I don't know

15. How often did you smoke marijuana or hash during the 3 months before you found out that you were pregnant? *(Mark X in only one box.)*
    Several times a week
    Several times a month
    Occasionally, or rarely
    Never

16. How often did you use cocaine or crack during the 3 months before you found out that you were pregnant? *(Mark X in only one box.)*
    Several times a week
    Several times a month
    Occasionally, or rarely
    Never

17. How often did you use heroin, speed, acid, amphetamines, PCP, inhalants, etc. during the 3 months before you found out that you were pregnant? *(Mark X in only one box.)*
    Several times a week
    Several times a month
    Occasionally, or rarely
    Never

E. NUTRITION

1. How much did you weigh before you became pregnant this time? _____ pounds
   How tall are you? _____ft. _____ inches

2. What do you weigh now? _____

3. Have you ever vomited to control your weight or vomited to feel better after eating too much?
    No
    Yes

4. Do you vomit often now?
    No
    Yes

5. Are you having any of the following symptoms now:

Nausea	No	Yes
Heartburn	No	Yes
Constipation	No	Yes

6. When you were not pregnant, did you feel that your weight and your body shape were:
    About right
    Overweight/too large
    Underweight/too small

7. Are you on a special diet **now**?
    No
    Yes Kind:_____

8. Do you eat corn starch out of the box, laundry starch, paint chips, lots of ice, clay, dirt or other things that are not food?
    No
    Yes

9. During the past month did you miss any meals or not eat when you were hungry because there wasn't enough food or money to buy food?
    No
    Yes

10. Do you have a working stove and refrigerator?
    No
    Yes

Key > = greater than
< = less than

Points (subtotal)_____

F. RELATIONSHIPS

1. How do you feel now about being pregnant?
   - Very happy
   - Unsure--a little bit happy and a little bit unhappy
   - Very upset about it

2. How does your husband or partner feel now about you being pregnant?
   - Very happy
   - Unsure--a little bit happy and a little bit unhappy
   - Very upset about it
   - He doesn't know I'm pregnant

3. How often did you feel depressed during the last week?
   - Rarely (less than 1 day)
   - Some of the time (1-4 days)
   - Most or all of the time (5-7 days)

4. How many living children do you have? _____

5. How many of them are living in your household now? _____

6. Within the last 12 months, have any of your children been taken from you?
   - No
   - Yes

7. Have you had sexual contact with any of following:

HIV Infected partner?	No	Yes	Not Sure
An IV drug user?	No	Yes	Not Sure
A bisexual partner?	No	Yes	Not Sure
A hemophiliac?	No	Yes	Not Sure

8. Have you given or received money or drugs for sex?
   - No
   - Yes

9. Does your partner have a problem with alcohol or other drugs?
   - No
   - Yes

10. Does anyone else in your family have a problem with alcohol or other drugs?
    - No
    - Yes

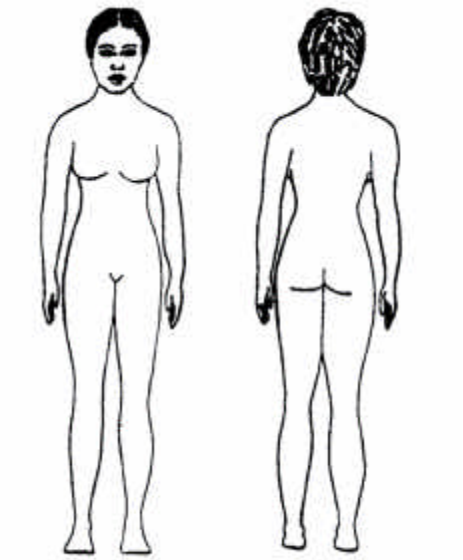
    What relation is this person to you?
    _____

11. Have you **ever** been emotionally, verbally or physically abused by your partner or someone close to you?
    - No
    - Yes

12. Have you been hit, slapped, kicked, or otherwise physically hurt by your partner or someone close to you?
    - No
    - Yes

13. Since you have been pregnant, were you hit, slapped or kicked, or otherwise physically hurt by someone?
    - No
    - Yes
    - If yes, by whom?_____

Mark the place on the picture of the woman to show where you have been hurt by your partner or someone close to you.



Adapted from the March of Dimes

14. Has anyone forced you to have sexual contact?
    - No
    - Yes
    - If yes, by whom?_____

Key > = greater than
< = less than

Points (subtotal)_____

15. Have other family members been sexually assaulted or abused?
    No
    Yes

16. Are you afraid of your partner or anyone else?
    No
    Yes

17. Is there a gun in your home?
    No
    Yes

18. Is there someone you can talk to when you a have a problem?
    No
    Yes

19. How many people can you really count on when you need help?
    No one
    1 - 2 persons
    3 or more persons

List:_____
_____
_____
_____

20. What do you do to deal with your problems?
_____
_____
_____
_____
_____

G. WORRIES

1. Which of these things worry you a lot? *(Check the ones that are big problems.)*
    Money problems
    Labor and delivery
    Transportation
    Losing this baby
    My job
    Caring for this baby
    My partner's job, or unemployment
    Caring for my other children
    Housing problems/getting evicted
    Getting child care
    My partner's drinking or drug use
    My health
    My own drinking or drug use
    My own safety
    Worry about my relationship with my partner
    Worry whether this baby will be all right
    My partner is in jail

2. How often do you have problems getting transportation?
    Very seldom
    Occasionally
    Quite often
    Most of the time

Please write down here anything else that worries you a lot:

_____
_____
_____
_____
_____
_____
_____
_____

_____
Staff Signature/Date

Points (subtotal)_____

Total *(all pages)*_____